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# Mental Health Oversight Advisory Council
# Ground Rules: Shared Expectations

**First Adopted on October 13, 1999**
**Revised September 2000, August 2001 and July 2003**

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## 1.0 INTRODUCTION

1.1 The 1999 Montana legislature, via SB 534, directed the Department of Health and Human Services (Department) to create a Mental Health Oversight Council (Council).

1.2 At its first meeting on August 16, 1999, the Council asked the Montana Consensus Council to help it develop a work plan and set of ground rules to govern the Council.

1.3 The Consensus Council agreed and produced the first draft of this *working document* based on intensive interviews with the original members of the Council (in the fall of 1999).

1.4 *Working document* means the Council revises this document to suit its evolving needs and focus over time. Any member of the Council is free to suggest changes to this set of group guidelines.

1.5 The Council understands that the work plan describes its primary focus of work. The Council also encourages others to recognize the Council as the primary forum for conversation for issues that are defined by its work plan.

## 2.0 STATUTORY PURPOSE/COMPOSITION OF THE COUNCIL

2.1 MCA 53-21-702(4)(a-d) says:

(a) The department shall form an advisory council, to be known as the mental health oversight advisory council, that is not subject to 2-15-122 M.C.A. to provide input to the department in the development and management of any public mental health system. The advisory council membership must include:

(i) one-half of the members as consumers of mental health services, including persons with serious mental illnesses who are receiving public mental health services, other recipients of mental health services, former recipients of public mental health services, and immediate family members of recipients of mental health services; and

(ii) advocates for consumers or family members of consumers, members of the public at large, providers of mental health services, legislators, and department representatives.

(b) The advisory council under this section may be administered so as to fulfill any federal advisory council requirements to obtain federal funds for this program.

(c) Geographic representation must be considered when appointing members to the advisory council in order to provide as wide a representation as possible.

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(d) The advisory council shall provide a summary of each meeting and a copy of any recommendations made to the department to the legislative finance committee and any other designated appropriate legislative interim committee. The department shall provide the same committees with the department's rationale for not accepting or implementing any recommendation of the advisory council.

2.2 Based on the original interviews with members of the Council (1999), the role of the Council also includes:

A. Provide an ongoing forum for providers and consumers.
B. Provide leadership and advocacy for the mental health system.
C. Foster cooperative relationships among consumers, providers, the Department, and other interested parties.
D. Make specific recommendations to the department and the legislature.
E. Provide input and advice in developing an effective system for delivering mental health services ... don't reinvent the wheel; take time to learn from other states; identify best practices; build on what we have.
F. Encourage the Department to clarify what it can and cannot do; to listen and respond to the needs and interests of consumers and providers; to clearly articulate its interests, priorities, and constraints.
G. Monitor, evaluate, and seek to continuously improve the system.

2.3 The Council helps the Department set major policy direction. The Council doesn't spend its limited time on brush fires, case work or most nitty gritty implementation details.

## 3.0 MISSION

3.1 Partners in planning for a recovery-based mental health system throughout Montana.

3.2 MHOAC encourages mental health system change that is consistent with the following working principles:

A. Recovery and Resilience
B. Equity, access and satisfaction
C. Cultural competency
D. Community-based solutions
E. Community education and awareness
F. Flexibility
G. Diversion
H. Address co-occurring disorders
I. Fiscal responsibility

## 4.0 GUIDELINES FOR GROUP PARTICIPATION AND PUBLIC INVOLVEMENT

4.1 Participation *values*:
synergy – recognize that no one can do alone what this Council can do together;
democracy -- practice full participation, self-determination, and shared responsibility;
community – nurture relationships and work to keep everyone at the table;
honesty – help others understand you, and work to understand others;
creativity – innovate, stimulate; flexibility – don't be a slave to the schedule or the routines;
efficiency – people's time is precious; treat it with respect;
acceptance -- trust that each will do their best and still mistakes will be made.

4.2 Be relevant; stay on the subject.
4.3 Express concerns. Be authentic – say what needs to be said.
4.4 Disagree with ideas, not people.
4.5 Build on others' ideas.
4.6 Assume there are no fixed ideas or undiscussables.
4.7 Invite laughter and creativity.

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4.8 Value lively debate and discussion. It can promote better outcomes.
4.9 Strive for closure where possible and summarize conclusions at the end of meetings.
4.10 All meetings of the Council are open to the public.
4.11 The Council will provide appropriate opportunities for public input and advice during each meeting. It may also call upon members of the public during the Council meetings.
4.12 Each member agrees to seek the advice or his or her constituents throughout the process.
4.13 Each member agrees to keep his or her constituents informed of ideas and activities emerging from the process.

## 5.0 ATTENDANCE, TERMS, REAPPOINTMENTS

5.1 Individuals are appointed to the Council by the Director of the Department for four-year terms.
5.2 Individuals may be reappointed to the Council for one four-year term.
5.3 Council members may not send a proxy to represent their interests but may send someone to listen on their behalf.
5.4 Except for unusual circumstances, a member of the Council shall be dismissed from the Council if he/she misses three consecutive meetings of the Council.
5.5 After the initial chair appointed by the Director serves his term, the Council will elect, by majority vote, its own chair and vice-chair to four-year terms.
5.6 When a Council member resigns or is no longer able to represent the interest he or she was appointed to represent at the table, the Director will appoint a new member for the unexpired term. As vacancies occur, the Council encourages timely appointments to ensure appropriate representation on the Council.
5.7 The Council encourages the Director to maintain a current roster of persons who have an interest in serving on the Council. The Council will assist the Director with outreach to potentially interested persons.

## 6.0 EXECUTIVE COMMITTEE AND OTHER COUNCIL COMMITTEES, TASK GROUPS

6.1 On December 14, 1999, the Council created an executive committee to foster communication between the Council and the Department and to accomplish tasks as assigned by the full Council.
6.2 The executive committee is composed of the chair, vice chair, one representative from each Council committee, the Addictive and Mental Disorders Division Administrator and the Child and Adult Health Resources Division Administrator.
6.3 From time to time, the Council will create committees and time-limited task groups to accomplish specific activities.
6.4 As a general rule, committees will address a range of interconnected issues over a longer period of time, while task groups will be assigned a very specific time schedule and expected work product.
6.5 As a general rule, anyone, whether they are a Council member or not, may serve on a committee or task group. However, only Council members may participate in the final approval of decisions or recommendations from a committee or task group.
6.6 When the Council makes a <u>formal</u> assignment of work to a committee or the executive committee or task group, they expect that group to bring conclusions back for full Council adoption. When the Council makes an <u>informal</u> assignment, the assigned group is <u>not</u> expected to bring conclusions back for full Council discussion or adoption.

## 7.0 WORKING RELATIONSHIP WITH LOCAL ADVISORY COUNCILS

7.1 In 1999, the Montana legislature, through SB 534 and later codifed at MCA 53-21-702, acknowledged the value of LACs and directed the Council to develop a provision for LACs to report to and meet on a regular basis with the Council. SB 534 also validated the importance of local participation in delivering mental health services by clarifying that LACs are to be included as one of the elements of a system of public mental health care.

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7.2 LACs are designed to complement, not duplicate or replace the regional mental health corporation boards (as defined in MCA 53-21-201).
7.3 The purpose of an LAC is to review and make recommendations about local public mental health services as well as provide input and recommendations to the Council.
7.4 As noted in the Local Advisory Council Policy the Council adopted September 13, 2000, the Council shall convene *at least* one meeting each year to listen to and exchange ideas with LACs. This meeting may be face-to-face or via telecommunication.

**8.0 GROUP DECISION MAKING**

8.1 Decisions/consensus building process: the Council uses the following method to test for consensus on proposals or Council recommendations. When there is a potential recommendation or substantive action item ready to test for agreement, the facilitator or the chair asks each member present to locate himself or herself on the following scale from agreement to disagreement:

1. I agree with the recommendation and will support it
2. I may still have a few questions, but can live with this recommendation and will not block it.
3. I cannot agree with this recommendation.

Consensus is reached when all present members register 1s or 2s. Any member registering a 3 assumes the responsibility of offering a constructive alternative or a suggestion about where and how to get more information to move the discussion along. Any member registering a 2 should do so only if the member is NOT compromising a dearly-held interest or value on which his or her constituency depends.

8.2 The above method is typically reserved for substantive issues under Council consideration. Many other routine questions are decided by a majority thumbs up/thumbs down vote.
8.3 Majority vote: In the absence of consensus as defined in 8.1, the Council will vote. Thus, the Council's consensus process may not always result in a consensus outcome.

**9.0 MEDIA RELATIONS**

9.1 The Chair of the Council is the only person that may speak to the media or others *on behalf* of the Council.
9.2 Each Council member may speak to the media regarding his or her own views, but may not speak on behalf of other members to the media or in other forums.

**10.0 FY 2004 – 05 Work Plan**

10.1 Committee Structure and Assignments: During FY 2004-05, the Council structure shall include four standing committees which will each focus on issues related to adult mental health issues, children's mental health issues, communications and development of the Service Area Authorities. The work of the committees will promote the Council's mission, encourage system change that is in accordance with the Council's working principles, promotes recovery and encourage serving people in the least restrictive and most appropriate setting.

A. <u>Adult Committee</u>

Committee priorities during FY2004-05 shall include:

1. Oversight and advice regarding development of peer support networks.
2. Oversight and advice regarding adequate medication for persons with chronic illness.

At its discretion, the committee also may work on the following:

3. Oversight and advice regarding further development and refinement of a system of care for adults.
4. Monitor implementation of the behavioral health inpatient facilities
5. Oversight and advice regarding mental health services for the chronically homeless.
6. Oversight and advice regarding services for people with co-occurring disorders.
7. Oversight and advice regarding pre-adjudication and diversion options for people with mental illness who have been incarcerated for legal offenses and transition planning for people with mental illness who will be released from prison.

B. Children's Committee

Committee priorities during FY2004-05 shall include:

1. Oversight and advice regarding the transition of children to the adult system.
2. Oversight and advice regarding issues related to the juvenile justice system and services for SED children who are on probation.

At its discretion, the committee also may work on the following:

3. Monitor implementation of DPHHS reorganization.
4. Oversight and advice regarding the interface between the Council and the Children's System of Care Planning Committee. The Council will honor and support MCC's role in system of care planning for SED children with multi-agency needs who are at risk of being placed in an out-of-home setting and earlier intervention to obviate the need for high end services. The Council also understands that resolution of issues related to the most resource intensive children has implications for the entire system of mental health care fore children.
5. Oversight and advice regarding a proactive process for developing statewide policies and priorities that define essential needs and core services for children, with an emphasis on evidence based practices, while acknowledging the reality of limited funding for public mental health services.

C. SAA Development Committee

Committee priorities during FY2004-05 shall include:

1. Oversight and advice regarding AMDD's plan for the transition to the administration of the delivery of public mental health services by service area authorities, with an emphasis on identification of barriers to system change and strategies for proactively responding to the corresponding resistance.
2. Oversight and advice regarding the development of SAA leadership committees
3. Oversight and advice regarding efficient operation of SAAs.
4. Oversight and advice regarding performance and outcomes measurement.

D. Communications Committee: The Communications Committee shall be comprised of a designated chair and two representatives selected from each of the other three standing committees.

Committee priorities during FY2004-05 shall include:

1. Identify barriers to effective communication among providers, between providers and AMDD and among all stakeholders in the public mental health system.
2. Develop recommendations for legislation.

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At its discretion, the committee also may work on the following:

3. Develop a formal communication plan, including clarification of the Council's responsibility to communicate with AMDD, the Legislature, LAC's, SAA's and the public, in general.
4. Identify barriers to implementation of the service area authority concept.
5. Develop a framework for standing reports and for periodic reports from major provider organizations and other groups. These reports should be more than status reports. The reports should provide information that is pertinent to the work of the Council and identify issues that may require Council response.

10.2 Legislative Priorities: During FY 2004 -05, the Council will review the following areas for potential legislation:

A. SAA management structure
B. Commitment law
C. Children's system of care

**11.0 ROLES AND RESPONSIBILITIES OF THE MONTANA CONSENSUS COUNCIL**

11.1 Subject to the availability of funding, the Consensus Council will help coordinate the work of the Council in a manner consistent with its Code of Professional Conduct. In particular, the Consensus Council is not an advocate for any particular interest or outcome. It seeks to be impartial – that is free from favoritism or bias either by word or action – and is committed to serving all parties rather than a single party.

11.2 The Montana Consensus Council's fee will be paid under a contract with the Department.

11.3 In the event that funds are not available for a contract with the Montana Consensus Council, the Mental Health Oversight Advisory Council will develop an alternative plan for coordination of its work.

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